Unexpected fatality review

408.1 PURPOSE AND SCOPE

This policy will provide guidance for compliance with RCW 70.48.510, Unexpected fatality review. This review is in addition to and following our internal In Custody Death Review (ICDR) processes. Corrections Manuel Policy number 723

408.2 POLICY

The chief law enforcement officer or designee responsible for the operation of the jail shall conduct an unexpected fatality review in any case in which the death of an individual confined in the jail is unexpected. The primary purpose of the unexpected fatality review shall be for the development of recommendations to the governing unit with responsibility for the operation of the jail. Key areas of this review will include:

- Post mortality review conducted by an independent medical practitioner. CM Policy 723
- Criminal/Coroner's investigation.
- Operational review conducted by the facility Administrative Lieutenant.

408.3 REVIEWER IDENTIFICATION

The chief law enforcement officer or designee shall convene an unexpected fatality review team and determine the membership of the review team.

The team shall comprise of individuals with appropriate expertise including, but not limited to, individuals whose professional expertise is pertinent to the dynamics of the case. The chief law enforcement officer or designee shall ensure that the unexpected fatality review team is made up of individuals who had no previous involvement in the case.

In most cases, subject to availability, Thurston County Corrections Facility will use the following members for its review panel.

- Representative(s) of Corrections Administration. (Chief, Operations Captain and Support Services Captain)
- Administrative Lieutenant. (Typically the author if the internal ICDR)
- Representative from Thurston County Risk Management.
- The Contracted Medical Director or designee.

The chief law enforcement officer or designee maintains the right to supplement or modify the membership of the review team.

408.4 REPORTING

Upon conclusion of an unexpected fatality review that is required pursuant to this section, the chief law enforcement officer or designee shall, within 120 days following the fatality, issue a report

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on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail.

Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and to the department of health.

An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, Confidential information may be redacted by the chief law enforcement officer consistent with the requirements of applicable state and federal laws.

No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

408.5 ACCESS TO DOCUMENTS

In any review of an unexpected fatality, the chief law enforcement officer or designee and the unexpected fatality review team shall have access to all records and files regarding the person or otherwise relevant to the review that have been produced or retained by the agency.

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